Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

King's Mill Hospital - Evacuation & Shelter Policy & Procedure

POLICY

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Foreword

Whole Hospital Evacuation Plan

Notes for Users

Aim of the Plan

The NHS Core Standards for Emergency Preparedness, state that all NHS Hospitals should have plans in place to evacuate the whole Hospital site, should there be a need to do so**.**

The Aim of this Whole Hospital Evacuation Plan is to provide the Hospital with a standardised and adaptable framework for planning for the whole-site evacuation of patients and staff from Kings Mill Hospital.

(NOTE:-This plan is in addition to the Trusts normal evacuation procedures such as Fire evacuation plans) and is supplementary to the Trust's over-arching Major Incident Plan.

Summary

The Plan includes the following key elements:

- Definition of key scales and stages of evacuation
- A description of the expected Command and Control Structures
- A description of a patient evacuation classification and evacuation triage mechanisms
- An example of hospital zoning systems for the site.
- A description of a standardised Patient Tracking System
- A list of designated areas of shelter, as advised by the Local Authority

Adapting National and Regional Guidelines & Policies

It should be noted that this plan utilises both national guidelines and agreed regional policies, in some sections. These sections are highlighted and, to ensure consistency of language and the

promotion of standard operating procedures, are **not to be amended** without consultation with the NHS England Area Team.

The sections in question are highlighted and are:

- Evacuation Definitions
- Stages of Evacuations
- Decision to Evacuate
- Incident Command Levels
- Patient Classification
- Dynamic Triage
- Hospital Zoning
- Traffic Management Planning
- Site & Asset Security
- Communications
- Recovery
- Hospital Evacuation Patient Tracking Form

If these sections are adapted locally then the Managers and the Trust should be aware of the potential legal implications, should they fail during a response.

The Managers and the Trust should also avoid any significant change to the layout, order or methodology of the template.

Good practice suggests that Hospital Zones should be created to aid evacuation planning and response operations. This will entail the identification of zones, identification of external patient and staff Muster Points and detailed site planning with the Ambulance Service.

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1.0 INTRODUCTION

1.1 The evacuation of the hospital will normally be the last resort when the lives and safety of the staff, patients and visitors are at risk. The decision will only be taken when all other options have been reviewed and totally exhausted and following a full risk assessment by the most senior person on duty at the time. This will normally be the Chief Executive or the On Call Director, in their absence.

The decision to evacuate a hospital would be taken jointly by the Trust Chief Executive/Strategic (Gold) Commander and the Senior/Middle Manager on call (Tactical (Silver) Commander), in conjunction with other multi-agency partners. The whole-site evacuation of the hospital site will be deemed a level one Major Incident and must be reported accordingly.

1.2 Possible scenarios that could render evacuation necessary are:

- Severe fire, where normal horizontal evacuation plans are no longer viable (see the Trust Fire Policy);
- Severe flood, where normal horizontal evacuation plans are no longer viable;
- Hazardous materials (HazMat)/Chemical, Biological, Radiological, Nuclear (CBRN) incidents, where the contamination is not contained within one area;
- Conventional terrorist incidents i.e. explosion;
- Catastrophic and prolonged utility failure;
- Major threat of any of the above;

These Plans are in addition to the Trusts normal evacuation procedures such as Fire evacuation plans.

This plan assumes that a Major Incident will be declared and the usual responses to the declaration of a Major Incident have been instigated.

2.0 POLICY STATEMENT

This Policy and appended procedures are designed to ensure that in the event of an incident where there is a requirement to evacuate part or the entire Kings Mill Hospital site, it will be conducted expeditiously, safely and effectively with minimum disruption to normal hospital activities

3.0 DEFINITIONS/ ABBREVIATIONS

3.1 Evacuation Definitions[1]

In the context of a healthcare facility, Table 1 defines the scales of evacuation:

Table 1 - Scales of Evacuation

Scale	Numbers	Context
Minor	up to 50 inpatients	evacuation of 1 to 2 wards
Moderate	50 – 100 inpatients	evacuation of a single floor
Significant	100 – 500 inpatients	evacuation of a building
Major	500+ inpatients	evacuation of an entire hospital facility

3.2 Stages of Evacuation

The evacuation of patient areas can seriously jeopardise the health, safety and welfare of patients, so it is critical to avoid unnecessary evacuation.

Table 2 sets out the Stages of evacuation and should be used to communicate to all staff and external agencies. **It is essential to use a single and common terminology.**

Table 2 - Stages of Evacuation

Stage 1	Minor	evacuation of 1 to 2 wards
Stage 2	Moderate	evacuation of a single floor
Stage 3	Significant	evacuation of a building
Stage 4	Major	evacuation of an entire hospital facility

The different Stages are not part of a phased process, so each Stage can be activated at any point of the incident. Consideration should be given to declaring 'Major Incident

Standby' at the earliest opportunity, allowing time for supporting agencies and services to get into a state of readiness.

If Stage 1 is activated but it does not then prove necessary to evacuate, it is essential that all agencies are 'stood down'.

Evacuation at Stage 4 will require the declaration of a 'Major Incident', if not already done so, and should be communicated externally to appropriate agencies

Note: - SFH will consider declaring a 'Major Incident' possibly at an earlier stage than Stage 4 suggested above.

4.0 ROLES AND RESPONSIBILITIES

This section details the General Responsibilities of all relevant persons and groups.

4.1 Trust Board

The Trust Board, through the Chief Executive (Accountable Officer), has overall responsibility for Health and Safety within the Trust and carries ultimate responsibility for providing a safe environment for Patients, Visitors and Staff.

4.2 Individual Officers

Hospital Strategic (Gold) Command Roles

The primary functions of Hospital Strategic Command are to;

i) Formulate a strategic plan for the evacuation and to communicate this with the Tactical/Silver Team, multi-agency partners and the CCG.

ii) Liaise with multi-agency partners to ascertain the method of transport and the onward destination of evacuated patients

iii) Recovery Planning Role

Hospital Tactical (Silver) Command Roles

The primary functions of the Hospital Tactical Command are to;

i) Designate evacuation zones according to the reason for the evacuation.
Inform Gold of the zones for onward communication to multi agency partners

II) Instigate the triage and classification of all patients being evacuated

ii) Maintain a list of all patients being transferred to sites outside the hospital

Hospital Operational (Bronze) Command Roles

The primary functions of the Hospital Operational Commands are to:

i) Triage patients into priorities for evacuation

ii) Evacuate the patients to the designated evacuation zones

iii) Ensure accompanying patient records are with the right patient or patient evacuation sheets are completed for every evacuated patient

iv) Provide assistance and expertise to ambulance services, including NHS, private or charitable ambulance services, with regard to individual patients' clinical needs

All other Trust Staff and contractors

Will comply with instructions from the Hospital Control Team

5.0 APPROVAL

The policy was approved at the July Resilience Assurance Committee meeting 2019 and ratified by the Risk Committee in August 2019.

6.0 DOCUMENT REQUIREMENTS

NARRATIVE AND PLAN ACTIVATION

6.1 Decision to Evacuate

The decision to evacuate either a ward, building or whole site is taken by the senior management (Silver and Gold Command) within the NHS organisation. Requests to evacuate can be made by the Police or Fire & Rescue Service but, ultimately, the final decision rests with the individual organisation's command and control team. If however, the reason for evacuation is due to an act or potential act of terrorism, the Police can order evacuation.

6.2 Triggers to Evacuate

Triggers to evacuate could include:

- Fire
- Flood
- Catastrophic utility failure
- HazMat/Chemical (CBRN) incident
- Unstable structure
- Intent to cause harm to groups of individuals

6.3 COMMAND AND CONTROL STRUCTURES

6.3.1 The command and control of a hospital evacuation is a mirror image of the Trust's Major Incident Plan. It is imperative that the structure is compatible with emergency services and is recognised by local partners.

The command structure invoked during an evacuation should mirror that of your individual Trust's Major Incident command and control plans. It should also mirror fire evacuation plans that will already be in existence for your Trust.

The Command and Control structure should use the same terminology as all other NHS organisations and that is commonly recognised by all emergency services. Table 3 sets out the levels of incident command.

Table 3 - Incident Command Levels

Strategic Command	Gold Command
Tactical Command	Silver Command
Operational Command	Bronze Command

6.3.2 Hospital Strategic (Gold) Command Roles

The primary functions of Hospital Strategic Command are to;

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ii) Liase with multi-agency partners to ascertain the method of transport and the onward destination of evacuated patients

iii) Recovery Planning Role

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i) Designate evacuation zones according to the reason for the evacuation.
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ii) Maintain a list of all patients being transferred to sites outside the hospital

6.3.4 Hospital Operational (Bronze) Command Roles

The primary functions of the Hospital Operational Commands are to:

i) Triage patients into priorities for evacuation

ii) Evacuate the patients to the designated evacuation zones

iii) Ensure accompanying patient records are with the right patient or patient evacuation sheets are completed for every evacuated patient

iv) Provide assistance and expertise to ambulance services, including NHS, private or charitable ambulance services, with regard to individual patients' clinical needs

6.3.5 Local Arrangements

This part of the local plan should also incorporate site specific details that deal with the following scenarios:

- No prior warning has been given for an evacuation
- Parts of the infrastructure are lost i.e. no power, unstable structure, fire
- Refer to local business continuity plans
- Hospital Control Room has to be relocated either to another building or off site
- Communication channels may be confused, restricted or unavailable Communication via KMH switchboard and refer local business continuity plans

Link to local Trust's Major Incident Plans and other Emergency Plans here:-

http://sfhnet.nnotts.nhs.uk/CorporateInfo/cmsbrowse.aspx?recid=3211&homeid=1

In addition, consideration should be given to ensuring that an identified and pre - planned recovery team are activated as part of the command and control process.

6.4 EVACUATION PRIORITISATION

6.4.1 Patient Evacuation Classification

In an evacuation situation, each patient in an individual clinical area will need to be prioritised and scored in order of evacuation. The most mobile and least dependant patients will be the first to evacuate, whilst patients with the highest dependencies remaining until appropriate care and support is in place to facilitate their safe evacuation.

Patients are to be reviewed by the most senior nurse at the time and classified as per Table 4:

Table 4 – Patient Evacuation Classification

Evacuation Priority 1	EP1
Evacuation Priority 2	EP2
Evacuation Priority 3	EP3
Evacuation Priority 4	EP4

As the notice for evacuation progresses, the patient classification, or scoring, will need to be reviewed. Where time is available and with provision of appropriate resources to support the onward transfer of critically ill patients, it may be realistic to evacuate those patients first, however, if a no notice full-scale evacuation is in progress, and then those same patients would move last from the inpatient ward area.

6.4.2 Dynamic & Reverse Triage

The concept of moving patients is based on doing **the most for the most**. It is important to recognise that the triage priorities in a full scale evacuation will be the reverse of that used during a normal emergency response.

Once a patient has reached their holding destination (external Muster Point) and is ready for onward transfer, the normal triage priorities are to be reinstated. Table 5 details the methods of Reverse Triage and the priorities for onward transfer.

Table 5 - Reverse Triage and Priorities for Onward Transfer

Triage Level	Reverse Triage Evacuation Priority	Priority for Onward Transfer
EP1/ P3	These patients require minimal assistance and can be moved **FIRST** from the ward. Patients are ambulatory and 1 x staff member can safely lead several patients who fall into this category to the holding area	These patients will be moved **LAST** as transfers from your hospital to another healthcare/reception facility
EP2/ P2	These patients require some assistance and should be moved **SECOND** in priority from the inpatient ward area. Patients may require wheelchairs or stretchers and 1-2 x staff members to aid transport	These patients will be moved **SECOND** in priority as transfers from your facility to another hospital

EP3/ P3	These patients require maximum assistance to move. In an evacuation, these patients move **LAST** from the inpatient ward area. These patients may at least require 2-3 x staff members to evacuate	These patients require maximum support to sustain life. These patients move **FIRST** once stable from your hospital holding area to another hospital
EP4/ P4	This category uses the '**three wise men'** principles in accordance with national ethical guidance. Its invocation is only for the period of time the incident is 'live'. Patients who are in this category are **unlikely to survive evacuation** from the hospital and would require significant resources to move them. They should only be moved once all other patients have been evacuated and if sufficient resources are available	These patients should only be transferred to another hospital if sufficient resources are available or if their remaining at the evacuated hospital endangers the lives of staff with them. All clinical care should be palliative

6.4.3 Evacuation Priority 1 - Independent or P3 Patients

Those patients who can self-evacuate will be encouraged to do so via a pre-designated Muster Point(s). EP1 patients will be evacuated to community and local authorities services i.e. Reception Centres, inpatient units or go home with appropriate records.

Reception Centres are to be supported by the evacuating trust's staff as follows:

- A senior nurse capable of managing/supporting nurses from other agencies (minimum Band 7)
- A senior manager to act a liaison officer for the hospital

The Reception Centres may need additional staff to be coordinated by the local CCG as follows:

- District nurses
- A GP
- GP Practice Nurses
- Local pharmacist(s)

6.4.4 Evacuation Priority 2 - Dependant or P2 Patients

There will be patients who require assistance to mobilise, which may involve the use of wheelchairs, beds, trolleys and ski pads etc.

These patients will need to be transferred to another facility that contains appropriate clinical equipment and with appropriate medical and nursing care.

A list of who these patients are, the care they need and where they are reallocated to must be kept by the Hospital Tactical Command. It is assumed that most of these patients will need stretcher-based ambulance transfers at the very least. Communication with the Ambulance Service and other ambulance providers must be effective to ensure appropriate use of blue light transfers.

6.4.5 Evacuation Priority 3 - Very Dependent or P1 Patients

Very dependant patients are those with clinical treatments and/or conditions that create a high dependency on staff. This will include those in critical care areas, operating theatres, coronary care units etc and those for who evacuation would prove potentially life-threatening.

6.4.6 Evacuation Priority 4 – Expectant or P4 Expectant Patients

There may be a need to prioritise which P4 patients are evacuated and it may be necessary to invoke a 'P4 Expectant' category, based upon guidance on ethical issues[2]. The evacuation triage category of 'Expectant' is to be used for those patients whose injuries or clinical support requirements are so extensive that they will not be able to survive evacuation and/or onward transportation, given the clinical care resources and time available.

The Expectant category arises when there are such large numbers of patients and the resources and the time to prepare patients for evacuation is severely limited, that the ability of the hospital to respond to the clinical needs of every individual during the

evacuation is compromised. Patients with potentially un-survivable injuries may not be evacuated, thus allowing the hospital, and other responding organisations, to do "**the greatest good for the greatest number".**

The Expectant category is only to be used with the authority of the hospital strategic management, following appropriate clinical diagnosis and discussion. This category uses the 'three wise men' principles in accordance with national ethical guidance.

6.4.7 Hospital Staff Not Engaged in Patient Evacuation

Staff not directly involved with the evacuation of patients should assemble at a pre-designed Muster Point(s) and await further instructions. These staff should not leave the site and should be prepared to be redeployed to assist further with the evacuation.

[2] NHS Emergency Planning Guidance 2009: *Planning for the evacuation and sheltering of people in health sector settings: Interim strategic national guidance Check Reference*

6.4.8 On-site Visitors, Contractors & Other Workers

All patients' visitors and other personnel such as contractors, visiting healthcare colleagues, shop staff etc on-site at the time of evacuation is assumed to be Evacuation Priority 1, unless otherwise proven.

6.5 HOSPITAL ZONING

6.5.1 Hospital zoning is a system that allows a hospital to be divided into naturally occurring sections, in order to ascertain what is contained within the individual zones and to aid the controlled evacuation of a specific area(s). Pre-designating evacuation zones also enable the Ambulance Service to bring patient-specific resources to pre-identified locations. Each zone is to be identified by colour using the recommended colours described in the national healthcare way finding guidance[3].

Each zone requires a pre-identified evacuation route either horizontally and/or vertically with an external Muster Point(s), should external evacuation from the building be necessary. An alternative evacuation route is also required in case the primary route is unusable.

Table 6 – Pre-designated Muster Points in Evacuation

Clinical Area	Muster Point	Evacuation Priority	Site Location
Ward 11	KTC Main Entrance	Medium	Tower 1
Ward 12	KTC Main Entrance	Medium	Tower 1
Ward 21	KTC Main Entrance	Medium	Tower 1
Ward 22	KTC Main Entrance	Medium	Tower 1
Ward 23	KTC Main Entrance	Medium	Tower 2
Ward 24	KTC Main Entrance	Medium	Tower 2
Ward 25	W&C Side Entrance	High	Tower 3
Ward 31	KTC Main Entrance	Medium	Tower 1
Ward 32	KTC Main Entrance	Medium	Tower 1
Ward 33	KTC Main Entrance	Medium	Tower 2
Ward 34	KTC Main	Medium	Tower 2

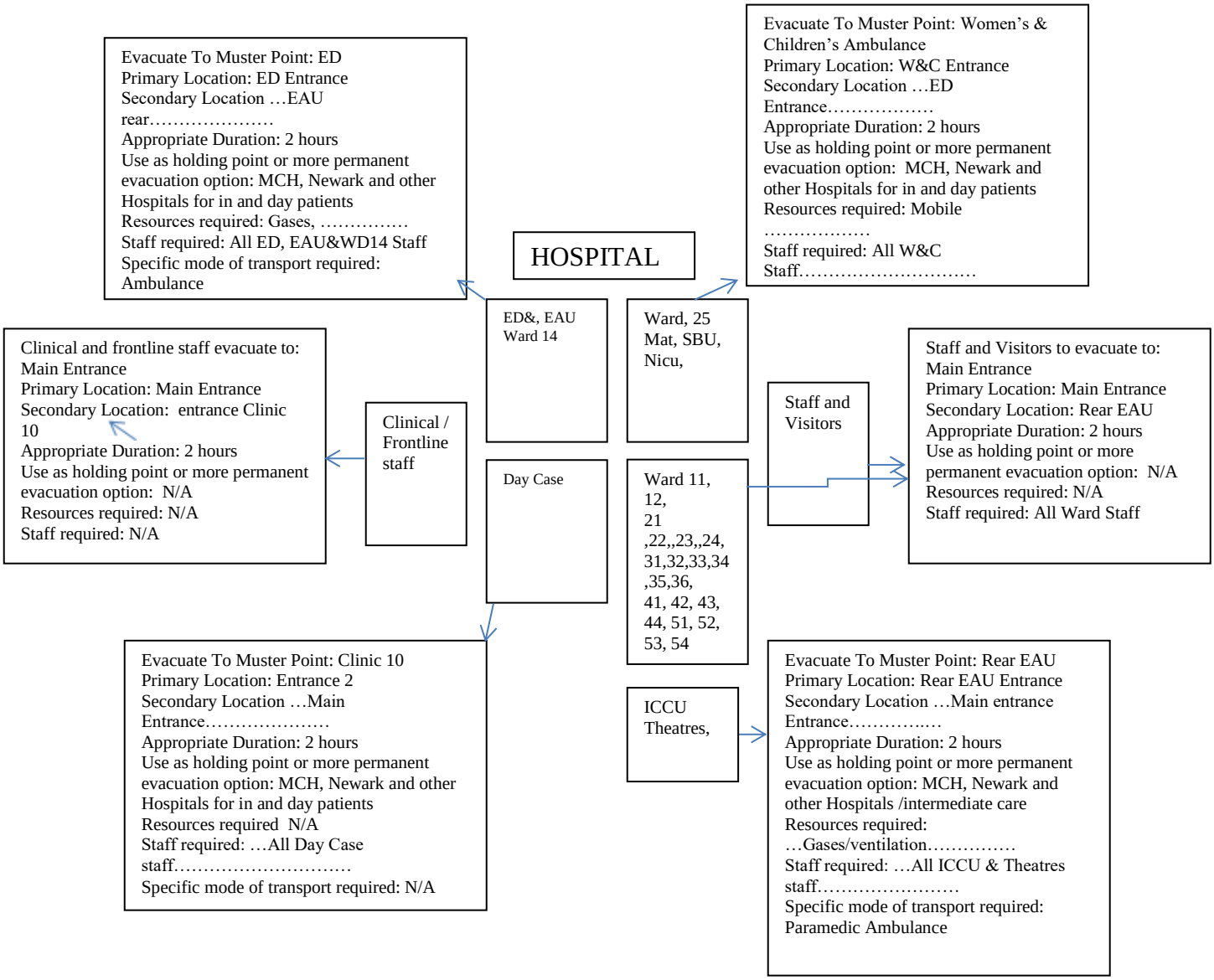
[3] Department of Health, Edition 2, 2005: Effective Wayfinding and Signing Systems Guidance for Healthcare Facilities Check Reference

	Entrance		
Ward 35	**KTC Main Entrance**	**Medium**	**Tower 3**
Ward 36	**KTC Main Entrance**	**Medium**	**Tower 3(if open)**
Ward 41	**KTC Main Entrance**	**Medium**	**Tower 1**
Ward 42	**KTC Main Entrance**	**Medium**	**Tower 1**
Ward 43	**KTC Main Entrance**	**Medium**	**Tower 2**
Ward 44	**KTC Main Entrance**	**Medium**	**Tower 2**
Ward 51	**KTC Main Entrance**	**Medium**	**Tower 1**
Ward 52	**KTC Main Entrance**	**Medium**	**Tower 1**
Ward 53	**KTC Main Entrance**	**Medium**	**Tower 2**
Ward 54	**KTC Main Entrance**	**Medium**	**Tower 2**
Maternity	**W&C Side Entrance**	**High**	**Tower 3**
SBU	**W&C Side Entrance**	**High**	**Tower 3**
NICU	**W&C Side Entrance**	**High**	**Tower 3**
Day Case	**Clinic 10 Entrance LGF**	**Medium**	**Tower 1**
Theatres	**Rear Doors(EAU)**	**Medium**	**Retained Estate**
Ward 14	**Rear Doors(EAU)**	**Medium**	**Retained Estate**
ICCU	**Rear Doors(EAU)**	**High**	**Retained Estate**
ED & EAU	**ED Entrance**	**Medium except Resus(High)**	**Retained Estate**

Where possible, Obstetrics, Gynaecology and Paediatrics patients should be evacuated to separate destinations from the main wards; this is to ensure that this cohort of patients receives appropriate specialist ambulance transport and that the safety of all children and babies is maintained. **The co-location of patients receiving these services is essential.**

6.6 King's Mill Hospital Evacuation Plan

The following is a diagrammatical representation of Kings Mill Hospital and the pre-identified locations of services once evacuated.



Managers need to be aware that designated Evacuation Muster Points may be unavailable; therefore a Dynamic Risk Assessment must be made to find alternative locations.

6.7 TRAFFIC MANAGEMENT PLANNING

During a full scale evacuation, it is key to ensure ambulances (blue light and patient transport) are able to enter and exit the site as quickly as possible. It is also important that visitors should be able exit the site and, where possible, this route should be different from any ambulance/emergency services route.

Each entry/exit road to the hospital site will need to be cordoned off to control the vehicles entering and exiting from the site. Visitors should be strongly discouraged from returning to the main hospital car parks and collecting their cars as this can create a gridlock, cause accidents and further hamper access to and from the hospital site by emergency vehicles.

6.8 SITE & ASSET SECURITY

6.8.1 During any evacuation, it is important that the security of the hospital site and its assets are maintained. The following areas should be planned for during each evacuation stage:

6.8.2 Stage 1 Evacuation

Designated senior nurse / Fire Marshal will conduct a full sweep of evacuated area to include; sluices, linen areas and toilets/bathrooms. Ensure drug cabinets are locked and the keys are evacuated with the staff.

6.8.3 Stage 2 Evacuation

Designated senior staff and Fire Marshals to conduct a full sweep as above, and report the area clear to Hospital Tactical (Silver) Command.

6.8.4 Stage 3 Evacuation

During a Stage 3 evacuation, the primary aims once evacuation is complete are to prevent unauthorised re-entry into the building and to protect the hospital's assets, as far as is reasonably practicable. Consideration should be given to controlling access using internal security manpower only.

Any mechanical 'locking down' systems should not be utilised at this point. As with Stages 1 and 2, designated senior staff with the assistance of Fire Marshals should conduct a full sweep of their areas of responsibility and report the areas clear to the Hospital Tactical (Silver) Command.

6.8.5 Stage 4 Evacuation

If it has been necessary to conduct a whole site evacuation, the prevention of unauthorised re-entry is the primary consideration. An authorised stand down is likely to be issued by the Police Service or the Fire Service in this instance.

Note: Staff Safety should not be compromised to achieve the above delegated Actions / Activities

6.9 COMMUNICATIONS

6.9.1 Internal Communications

In all Major Incidents, effective communication is paramount. It should be recognised that the use of the usual channels of communication may not be available in an evacuation situation. In such a situation, local information cascade plans and procedures should be adopted.

6.9.2 Table 7 details the communication cascade that should include the following:

Stage	Responders	Cascade
Standby	Gold and Silver command teams	Exec on Call Clinical directors, Divisional Managers, Matrons and Heads of Nursing
1- Minor	As per Standby plus affected Ward Managers	As per Standby plus staff, patients and visitors in affected areas
2- Moderate	As per stage 1 plus all Ward Managers & Departmental Managers	As per stage 1 plus all staff, patients and visitors in affected areas
2- Significant	As per stage 1 and 2 plus EMAS, Fire & Rescue, Police if a criminal act is suspected, surrounding local hospitals, CCG and NHS CB AT	As per stage 1and 2 plus all staff, visitors and patients on site
4- Major	As per stage 1-3 plus local media	As per stage 1-3 plus any additional site users/residents.

6.9.3 External Communications

Communications with external partners is essential to ensuring a safe evacuation of any hospital facility. In order to evacuate at Stages 3 or 4, assistance should be sought from the Ambulance Service at the earliest opportunity. The Ambulance Service will primarily facilitate the onward transfer of patients to another hospital but will also provide temporary hospital facilities to 'hold' patients until a suitable onward destination is secured.

At Stage 4, assistance from the Police will be required as soon as possible as they undertake key functions such as; closing surrounding roads to the evacuating hospital and redirecting traffic, setting up and running a casualty bureau (if appropriate) and the management of the scene if criminal activity is suspected.

The external media will also show interest if a full scale evacuation is instigated. They should be kept informed at regular briefing sessions and can also assist in providing public awareness messages to assist the hospital in keeping the public away from the site. **This should be in line with the local Major Incident Plans.**

6.10 PATIENT TRACKING

6.10.1 All patients **must be tracked during evacuation**. Whilst it is recognised that each individual hospital trust has differing patient record management systems, patient records should, where possible, go with the patient. In some cases, it may not be possible to take a full set of patient records with an evacuated patient and in this case, it should be realistic to only take the most relevant notes that relate to a patient's current episode of care. Individual trusts should make every effort to ensure the patients' records accompany the individual. However, there may be circumstances where it is impossible to evacuate the patient with their notes.

It should be noted that patient records are the property of the originating hospital trust and should be repatriated to that trust as part of the recovery process.

Appendix 5 contains a template Hospital Evacuation Patient Information Sheet.
Where time allows, the entire form should be completed and the use of a patient sticker is recommended.

As a minimum, the evacuating hospital should ensure that the patient has on his/her person the following details:

- Name
- Date of Birth
- Current prescription sheet (medicines)

- Clinical observation charts
- Allergies
- *Evacuation triage priority*

6.11 REDEPLOYMENT OF STAFF

6.11.1 Staff from the hospital may need to be redeployed in order to support the evacuated patients as the clinical care of evacuated patients will remain the responsibility of the affected hospital trust. The clinical care responsibilities extend until a formal handover is given to either an ambulance paramedic at the point of onward transportation or to an appropriately qualified member of staff at the receiving hospital, after transit.

As with hospital plans for managing pandemic influenza, this plan relies on existing trust policies for the redeployment of staff.

In the event of a full scale evacuation of the hospital site, staff will need to remain with patients that they have a designated duty of care to, during transit. The Ambulance Service will provide support to the hospital by the provision of equipment to sustain life support, onward transportation to receiving hospitals and temporary shelter. The Ambulance Service do not have resources to provide continuous nursing and medical care.

Hospital staff is a valuable resource, so plan for redeployment of staff and allocate a designated assembly point or Muster Station. Staff not involved in the direct care of evacuated patients should go to a pre-designated Muster Point and should be prepared to be redeployed.

The welfare of all hospital staff remains the responsibility of the evacuating hospital. Assistance for displaced persons can be sought from the LRF partners. It may be necessary to move staff to local authority Reception Centres.

6.12 ONWARD BED ALLOCATION TEAM

6.12.1 At Evacuation Stage 1+, a Bed Finding Team will need to be convened and should be run separately to, but not independently of, the Hospital Control Team-Tactical (Silver) Command Team.

The function of the Bed Finding Team is to liase with neighbouring trusts, to find and allocate beds for patients displaced as part of the evacuation process. The local responsibility for the assembly and co-ordination of this team could be the Ambulance Service or the responding CCG**.**

The membership of the team will be dependent on the scale and nature of the incident that has triggered the evacuation, but could include the following:

- Operational Managers
- Heads of Nursing
- Discharge team
- Critical Care Senior SpR
- Senior Midwife

- Representative from Ambulance Service
- Representative from Responding CCG
- Representative from Community Hospitals
- Representative from Adult Social Care
- Representative from Intensive Care Networks

6.13 RECEPTION CENTRES AND HOLDING AREAS

6.13.1 A hospital evacuation that results in patients having to move off site will require support from the LRF. It may be necessary to move patients to local authority managed Reception Centres, either for temporary shelter until they are able to return to the affected hospital or until they are able to be transported to another receiving hospital.

The responding CCG will act as liaison with the local authorities to ensure that emergency Reception Centres are set up and staffed appropriately and may include;

- A GP
- District nurses
- Nurse practitioner
- Pharmacist
- Social Worker – adult and child
- Spiritual leaders
- Voluntary Services (British Red Cross, St. John's Ambulance, WRVS etc)

6.13.2 If a temporary 'field' style holding centre is required, the Ambulance Service will lead the deployment of the facility, with support from Fire & Rescue Service and the responding CCG. In this instance, the redeployment of acute hospital staff to the temporary facility may be necessary.(As MCH is so close to KMH it is not envisaged that a temporary 'field' style holding centre will be required)

A Local Authority Humanitarian Rest Centre may be activated to act as a rest centre following liaison with the Local Council. Use of these facilities for patients or staff may not be guaranteed due to other commitments for space for local residents (see Appendix 13)

6.14 POST - INCIDENT

6.14.1 Recovery

Recovery planning should commence as soon as possible during the evacuation. Recovery and restoration of acute services are likely to be dictated by the circumstances at the time of the event, however the Recovery Plan must highlight some likely areas for consideration in the medium-long term including:

- Longer-term placements if it is not possible to reoccupy the site immediately
- Relief for evacuated staff & information for the next shift
- Support for friends and relatives of those patients evacuated to other hospital trusts
- Support for staff working temporarily at other sites
- Counselling for staff, as required
- Clear up and re-occupation of the site and return to 'new normality'

6.14.2 Debriefing

The evacuation of part or all of a hospital is a stressful event for staff, patients and visitors. At the earliest opportunity following 'stand down' a short 'hot debrief' should be held. This should allow staff to 'voice' pressing issues and express any immediate concerns that they may have. The debrief session should be kept short, structured and recorded.

Current guidance on supporting staff following a traumatic or highly stressful event recognises that after an initial short debrief, no further professional intervention (i.e. counselling) should be given. Staff should be given the opportunity to seek advice, reassurance and comfort from their close friends and relatives in the following 2 week period after the event, before seeking professional services. At this point, close monitoring of staff involved in the incident should take place, with support offered and given, where required.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Effectiveness of the Procedure	Author, Ward/Service, Dept Managers, EPO, Resilience Assurance Committee	Formal Review on a 3 year basis in line with Trust Risk Assessment and in line with local/national guidance .	Every three years	Author. Resilience Assurance Committee. Board Risk Committee
Monitoring Incidents and Learning	EPO, Resilience Assurance Committee, Board Risk Committee	Activity within the Incident De-brief process and in line with the Procedure	Every three years, or after any serious incidents	Emergency Planning Officer reporting to the Resilience Assurance Committee

Monitoring Compliance:

The Trust's Chief Executive will be responsible for ensuring that the Trust has effective arrangements in place to respond to a major incident or emergency. The Chief Operating Officer has been delegated as the Accountable Emergency Officer

- The monitoring and enforcement of compliance with the duties and statutory provisions of the CCA will be undertaken through mainstream performance monitoring arrangements.
- Within the Trust, the Accountable Emergency Officer will ensure that annual reports are submitted to the board outlining the current state of preparedness.
-

- Comply with any requests from Internal Audit, CCG or NHS England.

Comply with any requirements under the CQC's emergency preparedness standards

The Plan will be monitored by the Trust Resilience Team and any amendments / changes to the plan will be communicated to the relevant committee(s) / departments via the appropriate communication channels. A formal review of the plan will be undertaken every 3 years by the Trust Emergency Planning Officer.

8.0 TRAINING AND IMPLEMENTATION

It is recommended that the Trust Resilience Team conducts a desktop exercise each year for each of the Hospital Gold and Silver teams. The aims of these exercises are to:

- Improve / maintain awareness of the contents of the Hospital Evacuation Plan
- Ensure that the Hospital Evacuation Plan remains up to date
- Identify areas where the Hospital Evacuation Plan can be improved
- Practice the teams in working together.

Where possible these exercises should include participation from key stakeholders Such as the Ambulance Service, Police, the Fire & Rescue Service, the CCG and other Acute Trusts.

The Emergency Planning Officer r will produce a written Post-Exercise Report (PXR) after each exercise with specific recommendations for:

- Changes to the evacuation plans and possible investment in evacuation resources

Further training will be undertaken as appropriate. The Accountable Emergency Officer and Emergency Planning Officer will disucss these recommendations with Senior Management, Health and Safety Manager, LSMS and the Fire Officer to formulate an agreed Action Plan.

9.0 IMPACT ASSESSMENTS

This document has been subject to an Equality Impact Assessment, see completed form at Appendix 14

This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 15.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

1. Civil Contingencies Act 2004
2. Health and Social Care Act 2012
3. NHS England EPRR Framework Guidance 2015
4. Community Risk Register
5. NHS Emergency Planning Guidance 2005
6. NHS Emergency Planning Guidance 2009; Planning for the Evacuation and Sheltering of People in Healthcare Settings; Interim Strategic National Guidance
7. Improving hospital evacuation planning using simulation. Taafe K. et al 2006
8. Lessons learned from the evacuation of an urban teaching hospital. Cocanour. C. et al 2002
9. NHS London; Review of five London hospital fires and their management. September 2009
10. Evacuation planning for hospitals draft 2006. Continuum Health Partners Inc.
11. Department of Health, Edition 2, 2005: Effective Wayfinding and Signing Systems Guidance for Healthcare Facilities

Related SFHFT Documents:

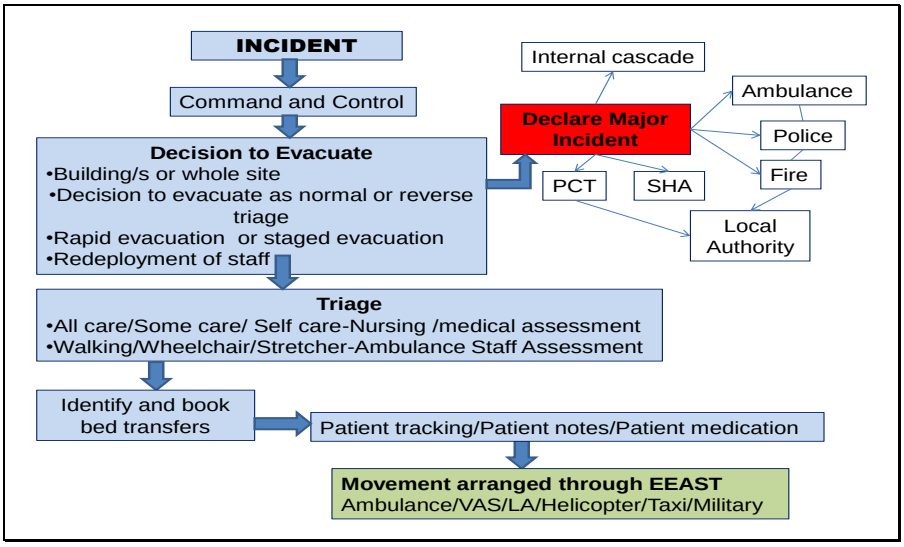
- Major Incident Plan
- Newark Whole Site Evacuation Plan

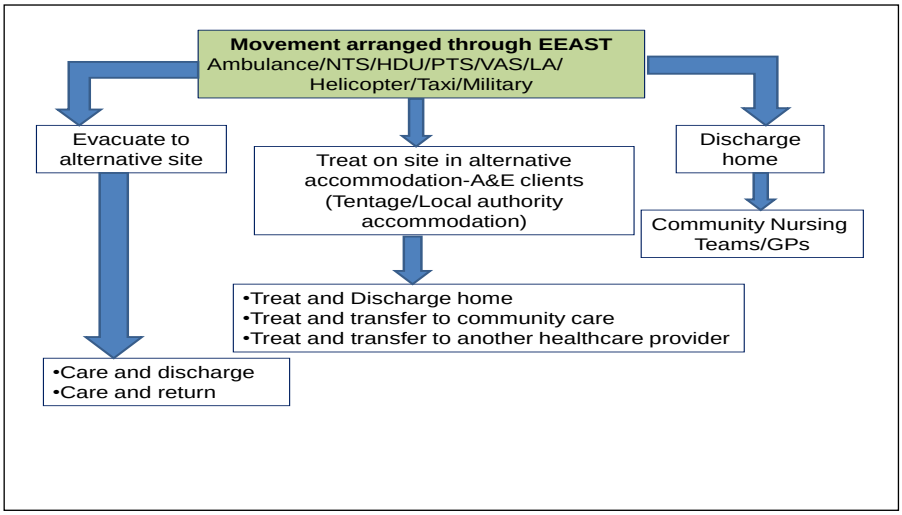
11.0 APPENDICES

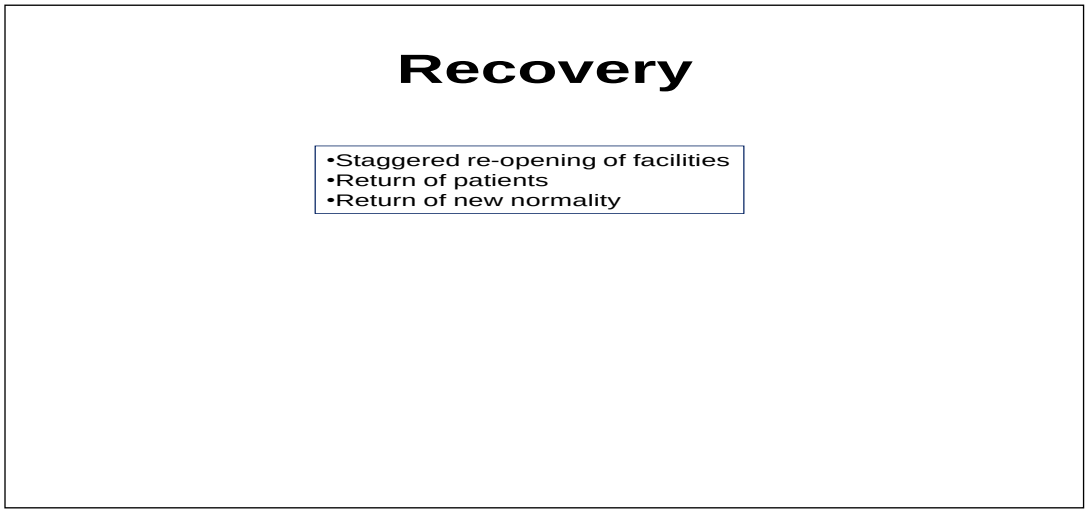
(See Contents Table)

11. APPENDICES

Appendix 1 EVACUATION FLOW CHART







Appendix 2 - BLUE LIGHT SERVICES KEY RESPONSIBILITIES

Ambulance responsibilities:-

- **Liaise with Acute Hospital Incident Management Team**
- Declare **Major Incident** if appropriate
- Deploy Mass casualties vehicle
- Deploy HART and use as appropriate
- Assess, resource and coordinate sufficient appropriate resources
- Liaise with other responding agencies
- Liaise with media teams for coordinated message
- Liaise with hospitals now taking diverted and evacuated patients
- Coordinate names and locations of transferred patient
- Assist with decontamination if required
- Provide and erect tentage and ancillary equipment as required
- Assist with triage and treatment as appropriate
- Liaise with Acute Incident Management Team to enable return or discharge of evacuated patients

Fire & Rescue Service

- **Liason Officer toAcute Hospital Incident Management Team**
- Declare **Major Incident** if appropriate
- Liaise with emergency responders
- Respond appropriately to incident
- Request Mutual aid if required
- Assist with evacuation

Police

- **Liaison Officer to Acute Hospital Incident Management Team**
- Declare **Major Incident** if appropriate
- Liaise with emergency responders
- Apply cordon if required
- Traffic management off site and on-site if appropriate
- Crime scene investigation
- Family liaison
- Casualty bureau if required

Appendix 3 - KEY ROLE ACTION CARDS

Acute Hospital Immediate Action Card for Senior Nurse/Manager			
Task	**Description**	**✓**	**Time**
1	Identify reason for Immediate Action to Evacuate		
2	Senior Nurse/Manager in conjunction with Fire Marshall to INVESTIGATE, DECIDE, and INSTIGATE evacuation of patient area		
3	Ring Trust Emergency Number (i.e. 2222) and give the following information: 1. Evacuation of 'Location' 2. Reason for evacuation 3. Number of Patients in situ		
4	Activate Fire Alarm		
5	Begin Reverse Triage of patients in area. Ask visitors to remain to assist with evacuation. 1. EP3 – Independent – First out 2. EP2 – Dependant – Second out 3. EP1 – Very dependant – Third out 4. EP4 (Expectant) – Very dependant and unlikely to survive – Last out		
6	Prepare patients to evacuate by: 1. Ensuring any fluid bags are detached from stands and a spare is available 2. Ensure sufficient blankets are with the patient 3. Explain need to evacuate to patient and any visiting friends/relatives 4. Ensure Patient ID wrist labels are in place on all patients		
7	Prepare staff to evacuate by: 1. Designating a member of staff to complete Patient Evacuation Information Sheet 2. Designate a member of staff to place all prescription cards, observation sheets and any integrated care plans with patient. 3. Collect staff rota and admissions diary 4. Designate named nurse to co-ordinate evacuation of patient cohort.		

Appendix 4 - ACUTE HOSPITAL EVACUATION METHANE ACTION CARD

Time of call: **Date:**

Name of Caller: **Department:**

Hospital: **Tel No:**

Major Incident	Declared or Stand-by (Inc Date & Time of Declaration)	
Exact location	Exact location / geographical area of incident	
Type of Incident	Flooding / Fire / Utility failure / HazMat / Disease outbreak etc	
Hazards	Present and potential	
Access	Best routes for access and egress / inaccessible routes	
Number of Casualties	Types and No's EP1, EP2, EP3	
Emergency Services	Required / On-scene	
Start a log	Intentions / Actions	
	Support / Mutual Aid required	

Appendix 5 - ACUTE HOSPITAL IMMEDIATE EVACUATION ACTION CARD

Blue Light Lead/First Responder at Patient Evacuation Point (PEP) Point			
Task	**Description**	**✓**	**Time**
1	Identify Safety of Area in conjunction with Police and Security where possible. Do not delay the security check waiting for Police or the security team. Secure Area in the best possible manner		
2	Identify a runner to liase with Hospital Control Room, to establish communication method and to handover patent information sheets		
3	Review reason for evacuation, and impact on hospital site		
4	Carry out instructions from hospital Control Room Commander		
5	Liase with first ambulance resource on scene to identify resources required to staff and equip triage areas. Allocate Clinicians on arrival. With Ambulance Service bronze identify priority use of Ambulance Service Major Incident Resources (tents, mass casualty vehicle, ambulances to triage areas) Establish with Ambulance Service Bronze ETA of any required resources and communicate with Hospital Control Team		
6	Establish Log of **all non acute hospital** persons entering and leaving the Casualty Clearing Area or any alternative triage area		
7	Establish staff support i.e. food water, shelter and rest area		
8	In the event of secondary event Revert to Step 1 of Action Card		

Appendix 6 CCG ACTION CARD IN THE EVENT OF ACUTE HOSPITAL EVACUATION

In the event of an Acute Trust Evacuation the CCGe Trust will			
	The Acute Hospital will notify the CCG trust Senior Manager On Call or Emergency Planning Lead of the incident and need to evacuate. Timings, numbers and support required should be given		
Task	**Description**	✓	**Time**
1	Confirm with the Acute Hospital: • the nature of the situation • associated timings • key risks • main priorities • if they require a CCG liaison officer within their incident management team		
2	Set Up Incident Control Room to support Trust and the response. Notify providers and LRF members as required. • Assist to facilitate hospital requests and need for assistance		
3	Notify Provider On Call and request the following information: • number of inpatient beds available • existing further capacity in the system • how much capacity could be made (discharge, RAG rating etc) • Provider on call to liase with social care		
4	Liase with Local Authority and Provider services to identify the most suitable sites for Evacuation of P3 patients and staff/visitors • Existing health site/centre for patients • Local Authority emergency assistance centres Activate where required		
5	**Patient Evacuation Centre** requires (depending on the size of the centre) similar staffing to that of mass casualty walk in treatment centre: • Senior Clinician / GP for oversight • Practice Nurses and Community Matrons to re-assess patient need • District nurse/health visitors etc for ongoing support • Social Care representation and assessment/input into patient care Wherever possible existing hospital staff should be utilised to support patients. Other staff include: • Registration/documentation • Refreshments		
6	Communications team to assist with public and media messages and handling		

Appendix 7 KEY CONTACTS LIST

External Stakeholders

Job Title/Location	Contact	Number
NHS Commissioning Board Area Team	On call Exec	**VIA CNCS Gateway**
Local County Council	Emergency Response Team	**0300 500 80 80**
CCG		**VIA CNCS Gateway**
East Midlands Ambulance Service	Control Managers Desk	**Via red phone ED**
Notts Police Constabulary	HQ-Gold Command/ Emergency Planning	**999**
Notts Fire & Rescue Service	HQ-Emergency Planning	**999**

Internal Key Contacts

Role	Number
Chief Executive	**3251**
Director of Operations	**3396**
Trust Fire Officer	**3057**
Director of Nursing	**3697**
Deputy Directors of Nursing	**4256**
Medical Director	**3546**
Consultant ED	**6403**
Lead Nurse ED	**2792**
Head of Nursing ED	**4123**
Dir- Paediatrics	**4286**
Estate and Facilities Director	**6496**
Discharge Team	**3038**
Gen Mgr – D&R	**3002**
Gen Mgr – PC & Surgery	**3008**
Gen Mgr – Emergency Care	**3029**
Div Manager – Women and children	**3008**
Head of Nursing – Surgery	**3012**
Head of Nursing - Medicine	**3028**
Director Communications	**3594**
Head of Midwifery	**3969**
ED Shift Leader	
ED Nurses station	
Emergency Planning Officer	**3551**

Appendix 8 HOSPITAL EVACUATION PATIENT TRACKING FORM

This section must be completed

Patients Details: Insert Sticker OR
Name
Date of Birth
Post Code

NHS No.: .....

Next of Kin: Name: ..... Relationship: .....

Address: .....

.....

Telephone No: ..... Contacted: Yes ☐ No ☐

GP (Name and Address): .....

Ward / Department: ..... Date: ..... Time: .....

Patient Triage: P1 ☐ P2 ☐ P3 ☐ See Table on Reverse

Transferred / Destination Ward / Unit within Hospital: .....

Transferred by: Print Name ..... Signature .....

Received by: Print Name ..... Signature .....

Designation ..... Time .....

All Patient Documentation Received: Yes ☐ No ☐

(If NO, comments): .....

Medical History (if known) / Allergies:

This section must be completed

To be completed if transferred to other health care provider or discharged

Name of other Health Care Provider: .....

Address transferred to: .....

Transported by VAS / PAS / EEMAS call sign ..... / TAXI / Other .....
See Table on Reverse

This form should be completed as far as possible and passed to the HOSPITAL CONTROL CENTRE immediately, irrespective of whether all the information is available or not. **Confidential Once Completed**

THIS PAGE IS TO BE PRINTED ON THE REVERSE OF APPENDIX 7, HOSPITAL EVACUATION PATIENT TRACKING FORM

Reverse Triage

Reverse triage is used in order to ensure the greatest amount of people are evacuated as quickly as possible

EP1 - Those who can evacuate with no assistance and can be described as Independent Able to provide for own needs without help from others

EP2 - Those who can evacuate with minimal assistance and can be described as Dependent Not able to provide for own needs without help from others

EP3 - Those who require full assistance for evacuation due to medical condition or lack of mobility and can be described as Very Dependent Not able to provide any of their needs without full help from others

EP4 - 'Expectant' is to be used for those patients whose injuries or clinical support requirements are so extensive that they will not be able to survive evacuation and/or onward transportation, given the clinical care resources and time available.

Transport

NHS	Ambulance Service Trust
VAS	Voluntary Aid Societies (Red Cross, St John Ambulance, Women's Royal Voluntary Service, 4 by 4 Response Service etc)
PAS	Private Ambulance Service

Appendix 9 CHECKLIST OF LESSONS IDENTIFIED – LONDON HOSPITAL FIRES

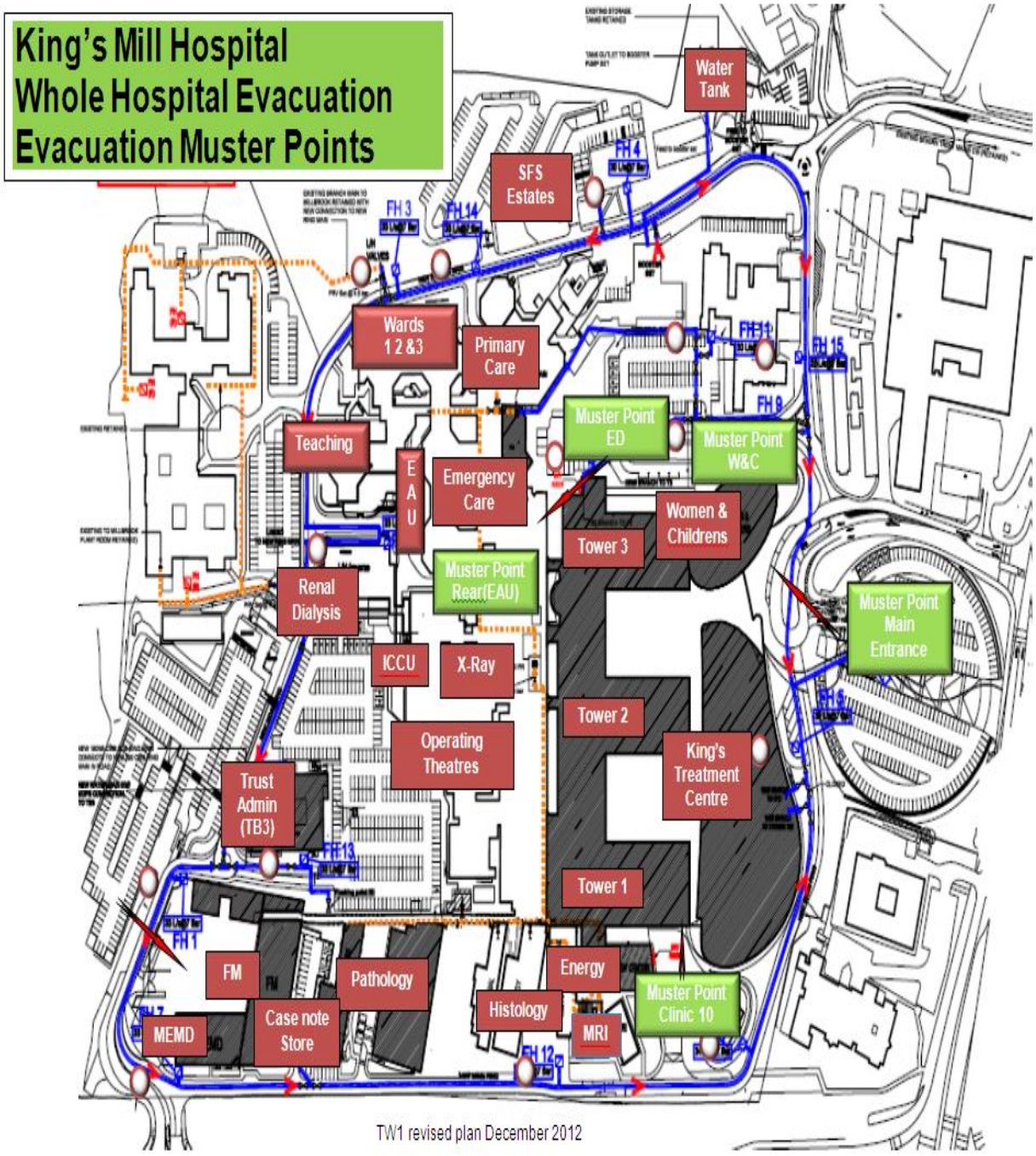
No	Issue	Solutions
Planning		
1	Those organisations that had comprehensive fire plans found this to be of substantial benefit to their response	Every NHS organisation develops and maintains a full site evacuation plan.
2	Site floor plans for fire fighters and rescuers	A fire service box in the reception to all NHS buildings – to contain full site maps (A3 [no bigger or smaller] laminated), floor plans, location of most vulnerable patients, locations of potential chemical and radiation hazards. Numbering of floors consistent with level in building. Consider numbering wards not naming.
3	Insurance cover amounts	Review insurance arrangements and ensure payouts are consistent with expectations and needs.
Command and Control		
4	A need for clear command and control structures	Clear definition of command and control for internal incidents including full evacuation. Ensure all roles have action cards available.
5	Incident commanders clearly visible	Tabards – bright tabards with key roles to be available and worn.
6	Command compatibility	Ensure command structure is compatible with emergency services and it is recognised and understood with local partners.
7	Decision making	Plans must be explicit in stating that in the event of a fire or security event it is not the responsibility of the emergency services to decide to evacuate an NHS facility – this is the absolute responsibility of the NHS organisations management.
8	Documentation	Ensure that the role of loggist(s) is included in the command and control arrangements.
9	Control resilience	Ensure an alternative incident control room off site for resilience.
10	Recovery	Ensure a recover team is identified and planned for – this team should be active during the acute phase of the incident.
Communication		
11	Loss of internal and external communications	Hand-held radios throughout the building at all key locations (training and familiarity required). Mobile telephones with key numbers stored (need for charging both prior and during incident). Email – this worked well with GOSH with many key staff having Blackberries. Runners – in some events these are not possible or safe.
12	Communication with external organisations and other NHS facilities	Early communication with partner NHS and external organisations is vital. This MUST be a defined role in the plan with all key telephone numbers. Remember to communicate early with the Health Protection Agency for advice on smoke and products of combustion and other, chemical and radiation issues.
13	Communicating with staff, relatives and patients	Flip charts – the Marsden used a number of flip charts on the cordon to keep staff, relatives and patients update. Websites – these are a good place to post information and direct people too – consideration must be given to how this could be updated off site. Text – text systems are available for staff providing numbers have been collected beforehand – this is useful for all incidents and internal continuity incidents.
14	Patient notes	Ensure a robust mechanism of evacuating patient notes with patients, including electronic notes where appropriate.
15	Evacuation routes	Regular review of exit routes including live tests to ensure space to evacuate patients in beds, mattresses/ski sheets and wheel chairs.
16	Evacuation equipment	All beds to have ski sheets under the mattress. Evacuation chairs at each stairway.

No	Issue	Solutions
Communication continued		
17	Patient tracking	Ensure a mechanism for tracking patient movements – dedicated command role with action card and tabard.
18	Clinical triage	Consider who and how evacuated patients will be triaged at point of exit for appropriate onward allocation.
19	Ambulance transport	Ensure that relevant requirements and command arrangements are written into private ambulance transport contracts for use in an emergency.
20	Patient shelter	Consider an offsite shelter location to hold patients in the initial stages of an evacuation.
21	Critical care patients	Consider detailed planning around the evacuation of critical care patients. Ensure that the patient shelter location has sufficient power points to maintain vital critical care equipment.
22	Mental health Patients	Planning required for managing mental health patients, especially those requiring specific security and pharmaceutical measures.
23	Immuno suppressed patients	Consider the sheltering of Immuno suppressed patients – not in the same location as other known infectious patients.
24	Pharmaceuticals	Consider how medications can be obtained from alternative organisations when planning non NHS facilities for patient shelters.
25	Onward inter-hospital bed allocation	Consider how beds can be found in other facilities for onward transfer.
26	Post incident	Ensure the long term psychological needs of evacuated patients is considered and planned for.
Staff		
27	Staff evacuation	It has been acknowledged that tracking staff during an evacuation is a challenge; however each organisation has a duty of care to know which staff is working within the building at any one time, including contractors. Staff lists are required during any fire evacuation and must be available at short notice.
28	Post incident	Do not assume that all staff will be able to continue working following the acute phase of an evacuation. Ensure systems are in place to support staff post incident.
Media		
29	Media strategy	Ensure the organisational incident media strategy encompasses full site evacuation. Consider 'buddy' system with other organisations for managing the media – especially around denial of premises.
30	Managing the media	DO NOT underestimate the volume of media interest in a full site evacuation event Consider a 'buddy' system with other organisations to share/utilise other communications team. Consider support from SHA communications teams.
31	Spokesperson	Ensure a dedicated and defined role of media 'spokesperson' – who is not involved in managing the event (ensure an action card).
Post event		
32	Recovery plan	Ensure a pre-determined recovery plan – as part of the organisations business continuity plan and full site evacuation plan.
33	Debriefing	Ensure a debriefing plan in place in advance – to include 'hot' debrief, internal debrief and multi agency debrief.
34	Event report	Ensure planning for a post incident report to be written and shared.
Training and exercising		
35	Staff familiarity	Ensure regular staff fire and evacuation training.
36	Command familiarity	Ensure regular fire and evacuation training with key incident decision makers.
37	Equipment	Ensure regular staff training in ski sheets and evacuation stair chairs.
38	Evacuation routes	Ensure staff is familiar with all evacuation routes which must be live tested on a regular basis.

Appendix 10 LIST OF ABBREVIATIONS

A&E/ ED	Accident & Emergency/ Emergency Department
AAU	Acute Admissions Unit
CBRN(e)	Chemical, Biological, Radiological, Nuclear, (explosive)
CB	Commissioning Board (NHS)
CCG	Clinical Commission Group
EMAS	East Midlands Ambulance Service
EP1 - 4	Patient Evacuation Priorities 1 to 4
ETA	Estimated Time of Arrival
GP	General Practitioner
HART	Hazardous Area Response Team
HazMat	Hazardous Material
EPLO	Emergency Planning Lead Officer
ID	Identification
LA	Local Authority
LRF	Local Resilience Forum
LSMS	Local Security Management Specialist
NHS	National Health Service
PAS	Private Ambulance Service
PEP	Patient Evacuation Point
PHE	Public Health England(HPA)
PXR	Post Exercise Report
P1- 3	Patient Treatment Priorities 1 to 3
SpR	Specialist Registrar
VAS	Voluntary Aid Services
WRVS	Women's Royal Voluntary Service

Appendix 11 Whole Hospital Evacuation Muster Points

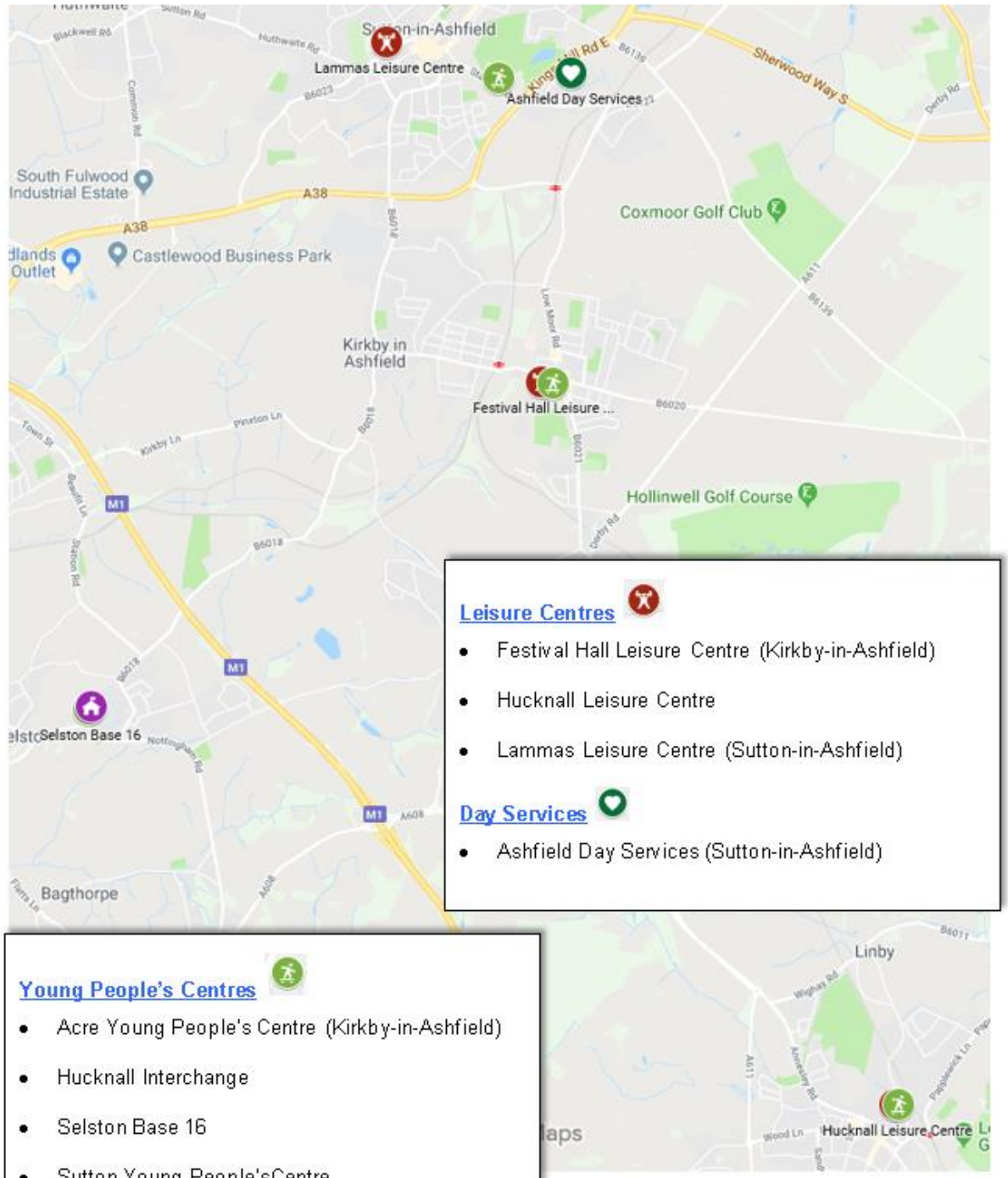


Appendix 12 EVACUATION MATRIX

Zone (Tower)	Area Name	Floor Level	Clinical Speciality	Total Patients	Total Mobile	Total Immobile	Additional people required	Means of Escape	Comments
1	Ward 11	1	T&O	24	24		6	Horizontal then vertical on foot, Beds, Evacuation Chairs and Mats	
1	Ward 12	1	T&O	24	24		6	"	
1	Ward 21	2	SAU & Surgery	24	6	18	6	"	
1	Ward 22	2	T&O	24	24		6	"	
2	Ward 23	2	Acute Cardiology	24	6	18	6	"	
2	Ward 24	2	Haematology & Cardiology	24	6	18	6	"	
3	Ward 25	2	Paediatrics	32	16	16	6	"	Gases
1	Ward 31	3	Surgery	24	6	18	6	"	
1	Ward 32	3	Surgery	24	6	18	6	"	
2	Ward 33	3	Gastro/Rheumatology	24	6	18	6	"	
2	Ward 34	3	Endocrinology	24	6	18	6	"	
3	Ward 35	3	DTOC	24	6	18	6	"	
3	Ward 36	3	Pressures Ward(if open)	24	6	18	6	"	
1	Ward 41		HCOP	24	6	18	6	"	
1	Ward 42		Respiratory	24	6	18	6	"	
2	Ward 43		Acute Respiratory	24	6	18	6	"	Gases
2	Ward 44		Respiratory	24	6	18	6	"	
1	Ward 51		HCOP/Neurology	24	6	18	6	"	
1	Ward 52		HCOP	24	6	18	6	"	
2	Ward 53		Acute Stroke	24	6	18	6	"	
2	Ward 54		Stroke Rehabilitation	24	6	18	6	"	
2	Ward 14	1	EPU Gynae	23	6	18	6	"	
3	Ward 25	2	Paediatrics	32	16	16	6	"	Gases
3	Maternity	1	Maternity	31	20	11	6	"	
3	SBU	1	Maternity	16	16		8	"	Gases

3	Nicu	1	Neonates	16	16		8	"	Gases
4 (Retained Estate)	Day Case	0	Surgery					"	Not 24/7
4 Retained Estate)	Theatres	0	Surgery					"	Gases Not all 24/7
4(Retained Estate)	ICCU	0	Intensive Care	8		8		"	Gases
4 (Retained Estate)	EAU	0	A&E					"	Gases
4 (Retained Estate)	ED	0	A&E	30	20	10	10	"	Gases

Appendix 13 - Local Area Rest Centres



Leisure Centres

- Festival Hall Leisure Centre (Kirkby-in-Ashfield)
- Hucknall Leisure Centre
- Lammas Leisure Centre (Sutton-in-Ashfield)

Day Services

- Ashfield Day Services (Sutton-in-Ashfield)

Young People's Centres

- Acre Young People's Centre (Kirkby-in-Ashfield)
- Hucknall Interchange
- Selston Base 16
- Sutton Young People'sCentre

Other sites

- Selston Leisure Centre

APPENDIX 14 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed:			
New or existing service/policy/procedure:			
Date of Assessment:			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	N/A	None
Gender	None	N/A	None
Age	None	N/A	None
Religion	None	N/A	None
Disability	Special arrangements may be required to move patients with chronic mobility problems	Specialised equipment, well trained staff, moving and handling experts	None
Sexuality	None	N/A	None
Pregnancy and Maternity	None	N/A	None
Gender Reassignment	None	N/A	None
Marriage and Civil	None	N/A	None

Partnership			
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	N/A	None

What consultation with protected characteristic groups including patient groups have you carried out?

None – in such an emergency evacuation will proceed at pace and without reference to any individual characteristics

What data or information did you use in support of this EqIA?

None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

No

Level of impact
From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact
For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Mark Stone – Emergency Planning officer

Signature:

Date: 26th June 22019